STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Karen Schimke
Executive Deputy Commissioner

April 19, 1996

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Eduardo Caballero Cacas, M.D.
REDACTED

Meissner, Kleinberg & Finkel
Richard A. Finkel, Esq.
275 Madison Avenue
New York, New York 10016

Ann Gayle, Esq.
NYS Department of Health
5 Penn Plaza-Sixth Floor
New York, New York 10001

RE: In the Matter of Eduardo Caballero Cacas, M.D.

Dear Dr. Cacas, Mr. Finkel and Ms. Gayle:

Enclosed please find the Determination and Order (No. 96-91) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by **certified mail**, upon the Administrative Review Board **and** the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

REDACTED

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:nm
Enclosure

STATE OF NEW YORK: DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

EDUARDO CABALLERO CACAS, M.D.

DETERMINATION
AND
ORDER

BPMC-96-91

EDMUND O. ROTHSCHILD, M.D., (Chair), **ROBERT B. BERGMANN, M.D.** and **MICHAEL A. GONZALEZ, R.P.A.** duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to § 230(10) of the Public Health Law.

MARC P. ZYLBERBERG, ESQ., ADMINISTRATIVE LAW JUDGE, served as the Administrative Officer.

The Department of Health appeared by **ANN GAYLE, ESQ.**, Associate Counsel.

Respondent, **EDUARDO CABALLERO CACAS, M.D.**, appeared personally and was represented by the Law firm of **MEISSNER, KLEINBERG & FINKEL, RICHARD A. FINKEL, ESQ.**, of counsel.

A Hearing was held on February 27, 1996. Evidence was received and examined, including witnesses who were sworn or affirmed. A Transcript of the proceeding was made. After consideration and review of the record, the Hearing Committee issues this Determination and Order, pursuant to the Public Health Law and the Education Law of the State of New York.

STATEMENT OF CASE

The State Board for Professional Medical Conduct is a duly authorized professional disciplinary agency of the State of New York. (§ 230 et seq. of the Public Health Law of the State of New York [hereinafter "**P.H.L.**"]).

This case, brought pursuant to P.H.L. § 230(10)(p), is also referred to as an "expedited hearing". The scope of an expedited hearing is strictly limited to evidence or sworn testimony relating to the nature and severity of the penalty (if any) to be imposed on the licensee[1] (Respondent).

Respondent, EDUARDO CABALLERO CACAS, M.D. is charged with professional misconduct within the meaning of § 6530(9)(c) of the Education Law of the State of New York ("**Education Law**"), to wit: professional misconduct ... by reason of ... "having been found guilty in an adjudicatory proceeding of violating a state or federal statute or regulation, ... and when the violation would constitute professional misconduct pursuant to this section (§ 6530);" (Petitioner's Exhibit # 1 and §6530[9][c] of the Education Law).

In order to find that Respondent committed professional misconduct, the Hearing Committee, pursuant to § 6530(9)(c) of the Education Law, must determine: (1) whether Respondent was found guilty, in an adjudicatory proceeding, of violating a state or federal statute or regulation; (2) that a final decision or determination was issued, with no appeal pending and (3) whether Respondent's violation would constitute professional misconduct under § 6530 of the Education Law.

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[1] P.H.L. § 230(10)(p), fifth sentence.

A copy of the Statement of Charges is attached to this Determination and Order as Appendix I.

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. These facts represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. All Findings and Conclusions herein were unanimous. The State, who has the burden of proof, was required to prove its case by a preponderance of the evidence. All Findings of Fact made by the Hearing Committee were established by at least a preponderance of the evidence.

1. Respondent was authorized to practice medicine in New York State on July 1, 1987 by the issuance of license number 170501 by the New York State Education Department (Petitioner's Exhibits # 1 & # 2)[2].

2. On December 7, 1992, Peter Mullany, from the office of Administrative Hearings of the New York State Department of Social Services, issued a decision in "In the Matter of the Appeal of Eduardo Cacas, M.D.", FH # 1619390K (Petitioner's Exhibit # 3).

3. Said decision affirmed the New York State Department of Social Services' determination to exclude Respondent from the Medicaid program for two years (Petitioner's Exhibit # 3).

[2] refers to exhibits in evidence submitted by the New York State Department of Health (Petitioner's Exhibit) or by Dr. Cacas (Respondents Exhibit).

4. Said decision also affirmed the New York State Department of Social Services' determination to seek restitution from Respondent for overpayment by the Medicaid program to Respondent of the sum of $142,862.00 (Petitioner's Exhibit # 3) (the sum of $142,862.00 was an extrapolation, allowed under the regulations, based on an audit of 14 written orders made by Respondent. The statistical sampling method was found to be an accurate determination of the total overpayment made {Petitioner's Exhibit # 3, p. 14}).

5. Said decision is annexed hereto as Appendix II. The Findings of Fact contained in that decision are not repeated at length in these Findings of Fact but are accepted by the Hearing Committee and are fully incorporated herein (Petitioner's Exhibit # 3).

6. Respondent was found "guilty" of engaging in an unacceptable practice as defined in § 515.2(b)(6)[3] of Volume 18 of the New York Code of Rules and Regulations ("**NYCRR**") (Petitioner's Exhibit # 3).

7. Respondent was also found "guilty" of engaging in unprofessional conduct as defined in § 29.2[4] of Volume 8 of the NYCRR (Petitioner's Exhibit # 3).

8. No further appeals are pending on the above decision, which is a final determination (Petitioner's Exhibit # 3).

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[3] Unacceptable recordkeeping. Failing to maintain records necessary to fully disclose the medical necessity for and the nature and extent of the medical care, services or supplies furnished, or to comply with the other requirements of [the Regulations]. (Petitioner's Exhibit # 3, p. 13).

[4] (a) Unprofessional conduct shall also include ... (3) failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. Unless otherwise provided by law, all patient records must be retained for at least six years ... (Petitioner's Exhibit # 3, p. 13).

9. Dr. Lilia C. Gonzalez testified about Respondent's competency, qualifications and reputation as a physician as well as Respondent's moral character and honesty [T-24-37][5].

10. Dr. Luz Sormillon testified about Respondent's competency, qualifications and reputation as a physician as well as Respondent's moral character and honesty [T-37-47].

11. Dr. Eustace Georgatos testified about Respondent's competency, qualifications and reputation as a physician as well as Respondent's moral character and honesty [T-47-57].

12. Eduardo Cacas, M.D. testified on his own behalf. He graduated from the University of Santo Tomas in Manila, Philippines in 1972. Since 1972, Dr. Cacas has almost exclusively worked in Hospital type settings. The exception appears to be from June 6, 1988 through July 10, 1989 where he practiced medicine in 4 separate locations in New York [T-18, T-63-70].

Respondent was Board Certified in pediatrics in the Philippines and is presently Board-Eligible (since 1987) in pediatrics in the United States

13. Respondent presented a number of "character" type affidavits and letters from various professional individuals (Respondent's Exhibits # A, B, C & E).

[5] Numbers in brackets refer to transcript page numbers [T-].

CONCLUSIONS OF LAW

The Hearing Committee makes the following conclusions, pursuant to the Findings of Fact listed above. All conclusions resulted from a unanimous vote of the Hearing Committee.

The Hearing Committee concludes that the following Factual Allegations, from the October 6, 1995 Statement of Charges, are SUSTAINED [6]:

Paragraphs A.: (2 - 5)

Paragraphs B.: (2 - 8)

The Hearing Committee further concludes, based on the above Factual Conclusion, that the SPECIFICATION OF CHARGES in the Statement of Charges is SUSTAINED

The Hearing Committee concludes that the Department of Health has shown, by a preponderance of the evidence, that Respondent was found guilty, in an adjudicatory proceeding, of violating state regulation 18 NYCRR 515.2(b)(6) and state regulation 8 NYCRR 29.2. The record also shows that the December 7, 1992 decision is a final decision and that no appeal is pending thereon. The Hearing Committee determines that Respondent's conduct constituted a violation of § 6530(32) of the Education Law, to wit: failure to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient.

[6] The numbers in parentheses refer to the Findings of Fact previously made herein by the Hearing Committee and support each Factual Allegation.

Therefore, the Department of health has proved, by a preponderance of the evidence, that Respondent's conduct, as alleged in the New York State Department of Social Services' proceeding does constitute professional medical misconduct under the laws of New York State. The Department of Health has met its burden of proof.

DISCUSSION

II Professional Misconduct under §6530(9)(c) of the Education Law.

As indicated above, Respondent has failed to maintain (or provide a copy of same when properly requested to do so) a record for each patient which accurately reflects the evaluation and treatment of the patient. § 6530(32) of the Education Law also requires that patient records be retained for at least 6 years.

The Hearing Committee determines that the information contained in the New York State Department of Social Services' December 7, 1992 decision was sufficient to show that at least 14 records of Respondent's patients were not maintained accurately or properly.

With regard to the testimony presented by Respondent and his character testifiers, the Hearing Committee evaluated and assessed them according to training, experience, credentials, demeanor and credibility. The Hearing Committee found all of the witnesses to be credible.

There were no issues regarding Respondent's medical care and treatment to any of the patients. There were also no indication that Respondent's conduct was anything but unaffected and proper in all respects in hospital type settings. The Hearing Committee evaluated all the testimony and evidence presented in arriving at a penalty as described bellow.

The Hearing Committee finds and determines that Respondent's conduct constitutes professional misconduct under § 6530(32) of the Education Law and therefore Respondent has violated § 6530(9)(c) of the Education Law, as indicated above.

DETERMINATION

The Hearing Committee, pursuant to the Findings of Fact and Conclusions of Law set forth above, unanimously determines that Respondent's license to practice medicine in New York State should be SUSPENDED for one (1) year; and said suspension should be STAYED. Respondent should be placed on probation in New York State for a period of two (2) years from the effective date of this Determination and Order; and Respondent must comply with the terms and conditions of probation contained in Appendix III. One of the terms of and conditions of probation should include that Respondent only works in a supervised setting such as a P.H.L. Article 28 institution and not in a private practice type of situation. Respondent's probation should be supervised by the New York State Department of Health, by the Office of Professional Medical Conduct.

This determination is reached after due and careful consideration of the full spectrum of penalties available pursuant to P.H.L. § 230-a, including:

(1) Censure and reprimand; (2) Suspension of the license, wholly or partially; (3) Limitations of the license; (4) Revocation of license; (5) Annulment of license or registration; (6) Limitations; (7) the imposition of monetary penalties; (8) a course of education or training; (9) performance of public service and (10) probation.

The Hearing Committee does acknowledges and specifically states that there was no issue or complaint in this matter regarding the quality of care provided by Respondent to any patients.

The Hearing Committee is not revoking Petitioner's license because there were no indication in the record of fraud or bad faith by Respondent. The Hearing Committee believes that Respondent, naively, did not know what he was getting into in the private practices that he began. However, when Respondent found out, he did get out. The Hearing Committee did positively view the number of professionals who came in to testify, as well as the letters of support submitted by Respondent.

It is for those reasons that the Hearing Committee believes a 2 year period of Probation with a limitation on a private practice will help Respondent, as well as adequately safeguard and protect the public funds.

Respondent's failure to maintain or provide adequate and accurate medical records can not be condoned. However, the Hearing Committee believes that Respondent is capable of learning from his errors and is capable of rehabilitation.

The Hearing Committee believes that a stayed suspension with 2 years of probation and a limitation on a private practice will better benefit society than a revocation of Respondent's license.

Taking all of the facts, details, circumstances and particulars in this matter into consideration, the Hearing Committee determines the above to be the appropriate sanctions under the circumstances. The Hearing Committee unanimously conclude that the sanctions imposed strike the appropriate balance between the need to punish Respondent, deter future misconduct and protect the public.

All other issues raised by both parties have been duly considered by the Hearing Committee and would not justify a change in the Findings, Conclusions or Determination contained herein.

By execution of this Determination and Order, all members of the Hearing Committee certify that they have read and considered the complete record of this proceeding.

ORDER

Based on the foregoing, **IT IS HEREBY ORDERED THAT:**

1. The Specification of professional misconduct contained within the Statement of Charges (Petitioner's Exhibit # 1) is **SUSTAINED**, and

2. Respondent's license to practice medicine in New York State is **SUSPENDED for one (1) year** from the effective date of this Determination and Order; and

3. The one (1) year **SUSPENSION is STAYED** as long as Respondent complies with the terms of probation; and

4. Respondent shall be on **PROBATION** in New York State for a period of **two (2) years** from the effective date of this Determination and Order; and

5. The complete terms of probation are attached to this Determination and Order in Appendix III and are incorporated herein; and

6. Respondent's probation shall be supervised by the New York State Department of Health, by the Office of Professional Medical Conduct; and

7. In the event that Respondent leaves New York to practice outside the State, the above periods of probation shall be tolled until Respondent returns to practice in New York State.

DATED: **Albany, New York**
April 19 **, 1996**

REDACTED

EDMUND O. ROTHSCHILD, M.D., (Chair),

ROBERT B. BERGMANN, M.D.
MICHAEL A. GONZALEZ, R.P.A.

Eduardo Caballero Cacas, M.D.

REDACTED

Meissner, Kleinberg & Finkel
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275 Madison Avenue
New York, NY 10016

Ann Gayle, Esq.
Associate Counsel,
New York State Department of Health
Bureau of Professional Medical Conduct
5 Penn Plaza, 6th Floor
New York, New York 10001

APPENDIX I

NEW YORK STATE DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

EDUARDO CABALLERO CACAS, M.D.

STATEMENT

OF

CHARGES

Eduardo Caballero Cacas, M.D., the Respondent, was authorized to practice medicine in New York State on or about July 1, 1987, by the issuance of license number 170501, by the New York State Education Department.

FACTUAL ALLEGATIONS

A. By Notice of Agency Action dated August 8, 1990, the New York State Department of Social Services (NYSDSS) notified Respondent that it had determined to exclude him from the Medicaid Program for two years because he had engaged in unacceptable practices and caused Medicad overpayments, and to seek restitution of overpayments in the amount of approximatly $338,800 (which was subsequently reduced to $142,682). This determination was the result of an audit of Respondent to determine whether his Medicaid patient records, for the period June 6, 1988 to July 10, 1989, documented compliance with Medicaid Program requirements regarding payment he received directly from the Medicaid Program. Respondent appealed said determination.

B. On or about December 7, 1992, in a Decision After Hearing, the Office of Administrative Hearings affirmed NYSDSS' determination to exclude Respondent from the Medicaid Program for two years and to seek restitution of overpayments in the amount of $142,682, in that Respondent was found to have engaged in unacceptable practice as defined in 18 NYCRR Section

515.2(b)(6), in that he failed to maintain records necessary to fully disclose the medical necessity for, and the nature and extent of, the medical care, services or supplies furnished, or to comply with the other requirements of the Regulations. Respondent was found to have also committed unacceptable practices under the general definition of 18 NYCRR Section 515.2(a), and to have engaged in unprofessional conduct under the regulation of the Department of Education at 8 NYCRR 29.2, in that he failed to maintain a record for each patient which accurately reflected the evaluation and treatment of the patient.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION
HAVING BEEN FOUND GUILTY OF
VIOLATING A STATE STATUTE OR REGULATION

Respondent is charged with committing professional misconduct as defined in N.Y. Educ. Law §6530(9)(c)(McKinney Supp. 1995) by having been found guilty in an adjudicatory proceeding of violating a state or federal statute or regulation, pursuant to a final decision or determination, and when no appeal is pending, or after resolution of the proceeding by stipulation or agreement, and when the violation would constitute professional misconduct pursuant to this section. (namely N.Y. Educ. Law §6530(32) (formerly N.Y. Educ. Law §6509 and 8 NYCRR 29.2)) as alleged in the facts of the following:

1. Paragraphs A and B.

DATED: October 6, 1995
New York, New York

REDACTED

ROY NEMERSON
Deputy Counsel
Bureau of Professional
Medical Conduct

APPENDIX II

STATE OF NEW YORK
DEPARTMENT OF SOCIAL SERVICES

In the Matter of the Appeal of

EDUARDO CACAS, M.D.

DECISION
AFTER
HEARING

from a charge of unacceptable practices and determination to seek restitution of Medicaid Program overpayments

FH# 1619390K

Before: John Harris Terepka
Administrative Law Judge

Held At: New York State Department
of Social Services
163 West 125th Street
New York, New York 10027
May 9, 1991; March 13, 26, 1992
Record closed August 28, 1992

Parties: New York State Department
of Social Services
295 Main Street Room 500
Buffalo, New York 14203-2405
By: Melvin R. Geyer, Esq.

Eduardo Cacas, M.D.
By: Richard A. Finkel, Esq.
Meissner, Kleinberg & Finkel
275 Madison Avenue
New York, New York 10016

(5)

JURISDICTION

Eduardo Cacas, M.D. (the Appellant) requested this hearing pursuant to Section 519.4 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (the Regulations), to appeal from a determination of the New York State Department of Social Services (the Department) to exclude him from the Medical Assistance for Needy Persons Program (the Medicaid Program) for two years, and to seek restitution of overpayments of Medicaid funds.

FINDINGS OF FACT

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. At all times relevant hereto, the Appellant was a medical doctor licensed to practice medicine in the State of New York and was a provider in the Medicaid Program, practicing medicine in several offices in upper Manhattan, the Bronx, and Brooklyn, New York City.

2. The Department is the State agency authorized to supervise the administration of the Medicaid Program and establish regulations to implement the program.

3. By Notice of Agency Action dated August 8, 1990, the Department notified the Appellant that it had determined to exclude him from the Medicaid Program for two years because he had engaged in unacceptable practices and caused Medicaid overpayments, and to seek restitution of overpayments in the amount of $338,806.66 plus interest at the legal rate.

4. The Department's determination was the result of an audit to determine whether the Appellant's Medicaid patient records documented compliance with Medicaid Program requirements. Services ordered by the

(6)

Appellant, including laboratory tests and prescriptions for which payment was made by the Medicaid Program directly to the service provider (ordered services), were audited for the period from June 6, 1988 to July 10, 1989.

5. The Department asked the Appellant to provide the patient records for a randomly selected sample of 50 of the 20,926 services which the Department's records showed were ordered or prescribed by the Appellant during the audit period. The total amount paid by the Medicaid Program for these 20,926 services was $338,806.66.

6. The Appellant failed to produce any of the requested records.

7. The Department was able to retrieve, from the third party providers, the original written orders for 15 of the 50 ordered services in the sample. The Appellant acknowledged that 14 of these were his orders. The 14 services are designated in the audit by sample numbers 3, 8, 13, 14, 22, 23, 27, 30, 34, 40, 41, 43, 46 and 50.

8. At the hearing, the Department reduced its restitution claim to $142,682. This restitution claim is based upon the Department's decision to hold the Appellant financially accountable for only these 14 of the 50 ordered services in the sample.

9. The $142,682 restitution claim is an extrapolation from the value of the 14 ordered services for which the Department seeks to hold the Appellant financially accountable, and is based upon a statistical sampling method certified as valid.

10. During the audit period the Appellant was treating patients, billing and being paid by the Medicaid Program, and ordering services for Medicaid eligible patients, solely under the authority of his medical license and his Medicaid provider number.

11. The Appellant failed to maintain and furnish to the Department documentation to support the medical basis and specific need for medications prescribed or tests ordered by him and paid for by the Medicaid Program.

ISSUES

Did the Appellant cause overpayments of Medicaid funds for which the Department is entitled to seek restitution?

Did the Appellant commit unacceptable practices in the Medicaid Program, and if so did the Department properly determine to exclude him from the Program for two years?

DISCUSSION

As is set forth in Section 363 of the Social Services Law, the Legislature established the Medicaid Program "to operate in a manner which will assure a uniform high standard of medical assistance throughout the state." Pursuant to SSL Section 363-a, the Department is charged with the duty to supervise the administration of the Medicaid Program and make such regulations, not inconsistent with law, as may be necessary to implement the Program. In furtherance of this obligation, the Department's regulations authorize, in certain circumstances, the two actions which are at issue in this hearing: 1) the imposition of sanctions, including exclusion from the Medicaid Program for a reasonable period of time, and 2) a claim for restitution of any amounts not authorized to be paid by the Program.

Most pertinent to this hearing decision are the Department's regulations at 18 NYCRR Parts 504 (Medical Care- Enrollment of Providers), 515 (Provider Sanctions), 517 (Provider Audits), 518 (Recovery and Withholding of Payments or Overpayments), 519 (Provider Hearings), and 540 (Authorization of Medical Care).

By enrolling in the Medicaid Program a provider agrees, pursuant to 18 NYCRR 504.3(a):

> ...to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request, to the department...

Failure by a provider to maintain records necessary to fully disclose the medical necessity for and the nature and extent of the medical care, services or supplies furnished is an unacceptable practice. Section 515.2(b)(6). The Department may impose sanctions, including exclusion from the Program, when unacceptable practices have been committed. Section 515.3.

The Department may require the repayment, with interest, of any amounts not authorized to be paid by the Medicaid Program, "whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake." Sections 515.3(b), 518.1, 518.4.

In this case the Department was reviewing services ordered by the Appellant, such as prescriptions and tests for which payment was made by the Medicaid Program to a third party pharmacy or laboratory. The Regulations at Section 518.3(b) provide specific authority for the recovery, from the ordering physician, of payments for services ordered by him when the medical basis and specific need for the services is not fully and properly documented in his patient records:

> The department may require repayment for inappropriate, improper, unnecessary or excessive care, services or supplies from the person furnishing them, or the person under whose supervision they were furnished, or the person causing them to be furnished. In this respect,

> the department may recover the amount paid for such care, services or supplies from the person ordering or prescribing them even though payment was made to another person. Medical care, services or supplies ordered or prescribed will be considered excessive or not medically necessary unless the medical basis and specific need for them are fully and properly documented in the client's medical record.

The Appellant's Failure to Produce Medical Records

The Appellant practiced medicine in three private offices in various sections of New York City. He was the only licensed physician in these offices. After he left these medical offices, at least two of them ceased to function as medical offices. During the time he practiced in these offices he saw and treated patients, billed the Medicaid Program under his name and Medicaid provider number, and received the payments from that billing. He also ordered, under his provider number, hundreds of thousands of dollars worth of services for payment by the Program.

The Appellant now claims that it is not his responsibility to make his medical records of these activities available to the Department. The patients, he says, were not his patients, and the charts, he says, are not his charts. He says he was only an employee of a "clinic," that the patients he treated were "clinic" patients, and that the charts were the property of the "clinics," which were responsible for any record keeping functions. He says that because the "clinics" are now closed or uncooperative he is unable to retrieve any records. He claims, therefore, that his failure to furnish the medical records is due to circumstances beyond his control for which he should not be held responsible by the Medicaid Program.

The Appellant's claim that these patients were somehow not his patients, and these records somehow not his responsibility to maintain, is not persuasive. Calling these medical offices "clinics" and calling himself an

(10)

"employee" does not alter his accountability to the Medicaid Program for a medical practice that was in fact operated solely under the authority of his medical license and his provider enrollment.

The Appellant said he was introduced by "a friend" to a Sam Mozafar who was the "operator" of the so-called clinics for which he worked. This "operator" - Mozafar is the only one mentioned at the hearing, although the Appellant's initial response to the draft audit report referred to more than one unnamed "operator" - made available the medical offices out of which the Appellant practiced. There is no evidence that this so-called clinic operator was anything more than his landlord. The Appellant acknowledged that Mozafar was "something like" his landlord. There is no evidence of any other business arrangement, let alone an employment agreement with any person or with any "clinic."

The Appellant's claim that the offices in which he practiced were, "for all practical purposes," shared health facilities within the meaning of Public Health Law Article 47 is not supported by any evidence. He has not even identified who he was supposedly sharing these facilities with, let alone established the other elements of the PHL Section 4702 definition of a shared health facility. At the audit entrance conference on May 21, 1990, after identifying what he now calls these "clinics," he specifically denied that he was affiliated with any shared health facilities.

None of these so-called clinics was constituted as a partnership or a professional service corporation or as a shared health facility, or as any other separate entity that might be considered to have undertaken recordkeeping responsibilities on the Appellant's behalf.

The Appellant now absolves himself of any responsibility for making

these medical records available for audit with the claim that "said charts and the patients concerned were neither his patients nor his charts." His position is untenable. This medical practice was conducted by him, in his name, under his provider number. He billed the Program for treating these patients, and he received the payments for treating them. These facts are uncontroverted. On the other hand, his bare assertion that the practice settings he describes were "for all practical purposes" similar to employment with a hospital or practice in a shared health facility is not supported by any evidence worthy of belief and, moreover, does not address the central issue in this case: Did he make any reasonable effort to comply with state regulations requiring him to maintain patient records and make them available if the Department asked to see them?

The reported cases cited by the Appellant all take for granted precisely what has not been proved in this case by any evidence worthy of belief: that <u>someone</u> was maintaining the medical records in compliance with the law. The cited cases are about ownership of records, not about a Medicaid provider physician's responsibilities to ensure that he has appropriate access to them.

Even if the Appellant believed that he was working in some kind of "clinic" operated by Mr. Mozafar, he was aware that he had recordkeeping responsibilities to the Medicaid Program. There is no credible evidence that when he did leave these "clinics" he left his records in the care of an identifiable custodian who took responsibility for them and who could be looked to for access if necessary.

The Appellant has failed to establish that any person or entity other than he, the provider physician, ever bore the recordkeeping responsibility

in this case. He has failed to establish that he ever relieved himself of that responsibility.

Unacceptable Practices

The Appellant has engaged in an unacceptable practice as defined in Section 515.2(b)(6):

> Unacceptable recordkeeping. Failing to maintain records necessary to fully disclose the medical necessity for and the nature and extent of the medical care, services or supplies furnished, or to comply with the other requirements of [the Regulations].

His argument that "unacceptable recordkeeping" is not an unacceptable practice without a separate finding of "fraud and abuse" is rejected. It is contrary to the plain meaning of 515.2(b), which is to specifically designate certain enumerated practices, unacceptable recordkeeping among them, to be unacceptable practices.

The Appellant has, furthermore, also committed unacceptable practices under the general definition of 515.2(a). In failing to maintain records for his patients, he has engaged in conduct which is contrary to the Department's regulations, and has engaged in unprofessional conduct under the regulations of the Department of Education at 8 NYCRR 29.2:

> (a) Unprofessional conduct shall also include...
>
> (3) failing to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient. Unless otherwise provided by law, all patient records must be retained for at least six years...

The Restitution Claim

At this hearing the Appellant has the burden of showing that the determination of the Department was incorrect and that all claims submitted and denied were due and payable under the Program, or that all costs claimed were allowable. Section 519.18(d). The burden is therefore upon him to

show that his orders are fully and properly documented in his patient records.

The Appellant did not meet his burden of proof because of his commission of unacceptable practices: He did not maintain and furnish the records, and he did not show good reason at this hearing for his failure to do so. The Department's determination that the 14 orders in question resulted in overpayments for which the Department may seek restitution from the Appellant, is affirmed. Section 515.3(b).

The audit was conducted by means of a statistical sampling method in which the Department selected for review a random sample of 50 services ordered or prescribed by the Appellant and paid for by the Medicaid Program. The 14 services disallowed in the sample were extrapolated to the "universe" of services which the Department's computer billing and payment records show were ordered by the Appellant and paid for by the Medicaid Program.

The specific ordered services in the sample, and a summary of the universe of claims from which they were drawn, are set forth in schedules attached to the Department's certification (Exhibit 7). These computer-generated documents prepared by the Department to show the nature and amount of payments made under the Program are entitled, under Section 519.18(f), to a presumption of accuracy which the Appellant offered no evidence to rebut.

Section 519.18(g) provides that an extrapolation based upon an audit utilizing a statistical sampling method certified as valid will be presumed, in the absence of expert testimony and evidence to the contrary, to be an accurate determination of the total overpayments made.

The Department did present certification from its statistician, Karl

Heiner, pursuant to this regulation. The Appellant, having presented neither expert testimony nor an actual accounting of all claims paid in rebuttal, failed to overcome the presumption of accuracy.

The total value of the 14 ordered services upon which Department bases its restitution claim is $340.92. Application of the estimation procedure set forth in Dr. Heiner's certification yields a total overpayment (rounded to the nearest dollar) in the amount of $142,682. A restitution claim in this amount, with interest, is authorized by the Regulations at Sections 518.1, 518.3, 518.4 and 515.3(b).

The Appellant suggests that the Department "unreasonably demands restitution in the amount of the point estimate of $140,000, when an equally as likely estimate of $66,000 results from the same statistical analysis." He claims in his brief that Dr. Heiner's certification:

> reflects the fact that the restitution estimate of $142,682 is merely a 'point estimate' on a 95% confidence interval, that any figure on that interval, including the low point of said interval, $66,398, is just as likely to be the amount that would result from an audit of the entire universe as would the point estimate.

Dr. Heiner's certification 'reflects' no such thing. To the contrary, it states that the point estimate used by the Department "is the maximum likelihood estimate, that is, it has the greatest likelihood of being the correct estimate." The Appellant has failed to carry his Section 519.18(d) burden of showing that the Department's overpayment figure is inaccurate.

The Exclusion of the Appellant from the Medicaid Program

Section 515.3(a) of the Regulations provides that upon a determination that a person has engaged in an unacceptable practice, the Department may impose sanctions, including exclusion from the Program for a reasonable period of time. Exclusion is defined at Section 515.1(b)(6), and means that

items of medical care, services or supplies furnished by the provider or ordered or prescribed by the provider will not be reimbursed under the Medicaid Program.

Section 515.4 lists the factors to be considered in the imposition of sanctions. The burden is on the Appellant to prove any mitigating factors affecting the severity of any sanction imposed. Section 519.18(d)(2). The Appellant has not established mitigating factors which warrant alteration of the Department's exclusion determination, or of the restitution claim.

The Appellant argues, in regard to the sanction, that the Department has not alleged that he defrauded the Medicaid Program, and that it did not investigate or consider his abilities as a physician. The absence of allegations or proof regarding such matters does not mean the Appellant's connection with the Medicaid Program cannot be terminated for other unacceptable practices.

During the period of this audit the Appellant was [redacted] in a setting which did not conform to either his own [redacted] He claims that "In protection of his own medical [redacted] and of the medicaid system as well, Dr. Cacas unilaterally terminated [redacted] with the "clinics" after a short and reasonable [redacted] reasonable [redacted] was by his own account, six months. During this time he [redacted] three different "clinics" at which he says he worked were [redacted] by his own account, by the [redacted] "operator." During this "short and reasonable time" he managed to write over 20,000 orders, at a cost to the Program in the amount of $338,000.

The Appellant's concern about the manner in which these "clinics" were operated, which he says caused him to terminate his relationship with them,

apparently did not extend to concern about his medical records. Now, as a direct result of his disregard of his recordkeeping responsibilities, the Department is unable to monitor, review or assess in any way what kind of medical care these orders and expenditures represent.

A provider's failure to maintain records to enable the Department to review care being paid for by the Medicaid Program undermines the integrity of the Program in both its quality of care and fiscal aspects, and is cause for legitimate and serious concern by the Department. The importance of this provider responsibility, and the consequences of ignoring it, are clearly set forth in the MMIS Provider Manual:

> 2.1.11 Record-Keeping Requirements
> ...The maintenance and furnishing of information relative to care included on a Medicaid claim is a basic condition for participation in the Program. For auditing purposes, records on Recipients must be maintained and be available to authorized Medicaid officials for six years following the date of payment. Failure to conform with these requirements may affect payment and may jeopardize a Provider's eligibility to continue as a Medicaid participant.

The Appellant acknowledged that he was familiar with this manual and acknowledged that he knew he might be held responsible for his charts at these "clinics."

A provider's participation in the Medicaid Program is contractual. As was stated by the Court of Appeals in Schaubman v. Blum, 49 N.Y.2d 375, 426 N.Y.S.2d 300 (1980):

> ... a provider of Medicaid Services has no vested right to continued participation in the program; rather, such participation is a privilege which may, in proper circumstances, be revoked. (See Schwartzberg v. Whalen, 66 A.D.2d 881.)

The Appellant disregarded his recordkeeping responsibilities to the Program for a significant period of time during which he was responsible for

hundreds of thousands of dollars in Medicaid expenditures. He has not established good reason to disturb the Department's decision to exclude him from the Program for two years.

DECISION: The Department's determination to exclude the Appellant from the Medicaid program for two years is affirmed. The Department's determination to seek restitution of overpayments of $142,682 is affirmed.

This decision is made by Peter Mullany, Office of Administrative Hearings, who has been designated by the Commissioner of the New York State Department of Social Services to make such decisions.

DATED: Albany, New York

DEC 07 1992

REDACTED

Peter Mullany
Office of Administrative Hearings

APPENDIX III

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TERMS OF PROBATION

1. Respondent shall conduct himself in all ways in a manner befitting his professional status, and shall conform fully to the moral and professional standards of conduct imposed by law and by his profession.

2. Respondent shall comply with all federal, state and local laws, rules and regulations governing the practice of medicine in New York State.

3. Respondent shall submit written notification to the Board addressed to the Director, Office of Professional Medical Conduct, (hereinafter "**OPMC**") Empire State Plaza, Corning Tower Building, Room 438, Albany, New York 12237, regarding any change in employment, practice, addresses, (residence or professional) telephone numbers, and facility affiliations within or without New York State, within 30 days of such change.

4. Respondent shall submit written notification to OPMC of any and all investigations, charges, convictions or disciplinary actions taken by any local, state or federal agency, institution or facility, within 30 days of each charge or action.

5. In the event that Respondent leaves New York to reside or practice outside the State, Respondent shall notify the Director of the OPMC in writing at the address indicated above, by registered or certified mail, return receipt requested, of the dates of his departure and return. The probation periods shall be tolled until the Respondent returns to practice in New York State.

6. Respondent shall have quarterly meetings with an employee or designee of OPMC during the periods of probation. In these quarterly meetings, Respondent's professional performance may be reviewed by inspecting selections of office records, patient records and hospital charts.

7. Respondent shall submit semi-annual declarations, under penalty of perjury, stating whether or not there has been compliance with all terms of probation (including the practice restriction set forth in ¶ 10) and, if not, the specifics of such non-compliance. These declarations and a Practice Restriction Declaration shall be sent to the Director of the OPMC at the address indicated above.

8. Respondent shall submit written proof to the Director of the OPMC at the address indicated above that he has paid all registration fees due and is currently registered to practice medicine as a physician with the New York State Education Department. If Respondent elects not to practice medicine as a physician in New York State, then he shall submit written proof that he has notified the New York State Education Department of that fact.

9. Respondent shall maintain legible medical records which accurately reflect evaluation and treatment of patients. These records will contain, at least, a comprehensive history, physical examination findings, chief complaint, present illness, diagnosis and treatment.

10. **Respondent's practice of medicine is restricted** to employment in a supervised setting, such as found in a facility licensed by the State of New York (PHL Article 28, New York State or City Department of Corrections, OASAS, etc.) Respondent must obtain prior approval from the Director or designee of any employment proposals. Respondent shall notify the Director of the OPMC before any changes in employment are made. This restriction shall be in effect until Respondent has fully completed probation.

11. Respondent shall comply with all terms, conditions, restrictions, and penalties to which he is subject pursuant to the Order of the Board. A violation of any of these terms of probation shall be considered professional misconduct. On receipt of evidence of non-compliance or any other violation of the terms of probation, a violation of probation proceeding and/or such other proceedings as may be warranted, may be initiated against Respondent pursuant to New York Public Health Law §230(19) or any other applicable laws.

12. All expenses, including but not limited to those, of complying with these terms of probation and the Determination and Order, including retraining and monitoring, shall be the sole responsibility of Respondent.